NC DIVISION MH/DD/SAS
2011 I/DD TARGETED CASE MANAGEMENT AUDIT

PROVIDER NAME:	**AUDIT DATE:**
PROVIDER #:	**NAME:**
CONTROL #:	**PROCEDURE CODE:**
MEDICAID #:	**SERVICE TYPE:**
DOB/AGE:	**SERVICE DATE:**
RECORD #:	**UNITS PAID:**

RATING CODES:	**O = No 2 = partially met 4 = Yes**	**6 = No service note 7 = Unable to identify service provider**	**8 = Repaid 9 = NA**	**RATING**
AUTHORIZATIONS/SERVICE PLAN (Use rating of "4", "0" or "9" for Q 1-3)				
1. a. Is an authorization in place covering this date of service? b. If NO, list dates: FROM_____TO_____				
2. a. Is there a valid service order for the service billed? b. If NO, list dates: FROM_____ TO_____				
3. a. Is the date of service covered by a valid Service Plan? b. If NO, list dates: FROM_____TO_____				
SERVICE DOCUMENTATION (Use Likert Scale See Instructions): (Use rating of "4", "2" or "0" for Q 5--8 and "4" or "0" for Q4 and 9—or ratings of 6, 8, or 9 as applicable)				
4. Does the service note(s) reflect a minimum of 15 minutes of service for the week of service billed?				
5. Is/are the service note(s) signed within the designated time frame by the person who delivered the service?				
6. Does the service note(s) relate to goals listed in the service plan? (purpose of contact)				
7. a. Does the service note(s) contain a description of an intervention? b. Does the service note relate to at least one of the four case management functions?				
8. Does the service note contain a description of the results or outcome of the case management activity (ies)?				
9. Is there a services note(s) of a quarterly face-to-face contact?				
QUALIFICATIONS/SUPERVISION/RECORD CHECKS: (Use rating of "4" or "0" for Q 10-12—or ratings of 7, 8 or 9 as applicable)				
10. a. Is there documentation that the staff is qualified to provide the service billed? b. If NO, list dates: FROM:_____ TO:_____				
11. a. Did the provider agency require disclosure of any criminal conviction by the staff person(s) who provided this service? b. If NO, list dates: FROM:_____ TO:_____				
12. a. Did the provider agency complete a Health Care Personnel Registry check prior to this date of service? b. If NO, list dates: FROM:_____ TO:_____				

COMMENTS:

AUDITOR:	**LME:**